INDEX OF DOCUMENTS

CONSUMER TASK FORCE
FEBRUARY 27, 2007

PROJECT UPDATES FOR FEBRUARY

PERSON-CENTERED PLANNING GUIDELINES - DRAFT

NOTICE & REGISTRATION FORM FOR THE MARCH 28TH SYSTEMS TRANSFORMATION GRANT, STRATEGIC PLANNING FORUM

DRIVING INSTRUCTIONS TO THE SHERATON HOTEL FOR THE ABOVE FORUM

CONSUMER TASK FORCE

UPDATE OF PROJECTS

FEBRUARY 2007

Self- Determination in Long Term Care Project
February 2007

As of this writing, February 15, 2007,there are 15 participants enrolled in Self Determination from Burnham Brook, UPCAP, Tri-County Office on Aging. They have all contracting with Guardian Trac as fiscal intermediary. Two fiscal intermediaries have had readiness reviews conducted. So far, the feedback from participants has been very positive, with reports of feeling "ecstatic".

We continuing to work out the "kinks" in the process as we make these initial enrollments, such as looking at the language in the agreements and the time it is taking to enroll. We have been working closely with two "mentors" from mental health as we work on budget policies. We are striving to make this as easy as possible for all concerned.

Policy and practice guidelines for Person Centered Planning are almost ready for review.

The quality measurement process and the phase in plan for the rest of the state are the priorities being addressed at this time. We will begin training the waiver agents on the changes in the waiver. A curriculum was developed for this.

I am still finishing an operations manual, and the quality measuring tools.

Michigan LTC Connections
February 2007

Vision

Each LTC Connection site is a highly visible and trusted source of information and assistance about long-term care, aiding Michigan residents with planning and access to needed services and supports, in accordance with their preferences

Information and Assistance The new software, Service Point is now available to the sites and each site is "populating" their resource data base. Our goal is to have comprehensive and accurate information about long term care services—both public and private.

Service Point will allow tracking of all callers, their request and referrals made. It will also collect data on unmet needs.

PA 634 The draft standards for Options Counseling are being rewritten to incorporate requirements set out in the new law. A workgroup has been working to encourage providers to partner with the LTCC so they options counselors can conduct functional eligibility determinations for persons wishing Medicaid funded long term care service. With the new law, the focus will change from partnership agreements to developing policies and capacity to conduct all level of care determinations.

Evaluation The Evaluation Steering Committee met to work on our Long Term Care Connection Logic Model Action Plan. This plan is due to the Administration on Aging on March 1st, but will remain a working document. Feedback for this task force has been incorporated, a copy will be provided to the task force at your next meeting

Training Weekly training is occurring, including training on Medicaid, Hospice service, person centered planning, and local services. Two joint trainings are being planned for March and

June. The topics will be Stage of Change and Chronic Disease, Options Counseling, caregiver assessment and understanding caregiver needs.

Contracts Efforts are underway to move 3 of the contracts from existing Area Agency on Aging organizations to the new independent entities. It is expected that new contracts will be in place April 1, 2007.

Medicaid Infrastructure Grant (MIG)
February 2007

There are presently 928 Freedom to Work (FTW) participants. This is up from 898 last month.

Medical Services Administration (MSA) worked with James Schwartz, Director, Administrative Support and Contract Development Section to gain concurrent coverage for MI Choice and Freedom to Work participants as noted below:

DATE: February 2, 2007
TO: MI Choice HCBSED Waiver Program Directors and Program Managers
FROM: James L. Schwartz, Director
Administrative Support & Contract Development Sect.
SUBJECT: MI Choice Operation's Advisory Letter #19
MI CHOICE HCBSED and Freedom to Work Program

Effective July 1, 2006 the Centers for Medicare and Medicaid Services (CMS) be approved the Michigan Department of Community Health's MI Choice HCBSED waiver amendment. That approved waiver amendment contains a provision that permits a MI Choice HCBSED waiver participant to also be concurrently enrolled in MDCH's Freedom to Work Program (FTW).

If you have any questions concerning this matter please contact your contract manager.

The MIG continues to work with MSA to address the other issues shown on the issues grid sheet forwarded each month.

- Teresa has asked MSA to consider another UNEARNED disregard for current FTW enrollees. Presently; if current enrollees begin to receive increased unearned income from a parent such as SSDI or Veteran benefits over the Federal Poverty Level, the enrollee would be ineligible for continued participation.

- The proposed letter to transition eligible persons from AD Care to FTW was given to MSA to polish and distribute as soon as possible.

Marty presented at Goodwill in Grand Rapids in mid-February. He also has presentations being scheduled at local SSA offices. He will have a FTW/work incentives booth at the Transition Conference in Frankenmuth on March 6. Marty has visited several club houses & drop-in centers to both share information on working and to better understand best practices in these settings as well as to share practices statewide.

Theresa is leading a committee focused on the "Expectation of Work" for individuals with disabilities. There will be efforts to challenge and change the myths that persons with disabilities are not able to work.

The MIG Workgroup are focusing on resource mapping of current strategies across Michigan to increase employment for people with disabilities. This will provide a foundation for a potentially larger 2008 grant submission that requires addressing a state wide strategic plan on employment.

Freedom to Work Enrollment
By County
February 2007

County Code	County Name	Beneficiary ID		County Code	County Name	Beneficiary ID
1	Alcona	2		40	Kalkaska	2
2	Alger	1		41	Kent	86
3	Allegan	10		43	Lake	2
4	Alpena	1		44	Lapeer	7
5	Antrim	6		46	Lenawee	13
6	Arenac	5		47	Livingston	8
7	Baraga	1		49	Mackinac	2
8	Barry	2		50	Macomb	55
9	Bay	35		51	Manistee	5
10	Benzie	3		52	Marquette	8
11	Berrien	29		53	Mason	6
12	Branch	5		54	Mecosta	6
13	Calhoun	19		55	Menominee	4
14	Cass	3		56	Midland	11
15	Charlevoix	8		57	Missaukee	2
16	Cheboygan	1		58	Monroe	14
17	Chippewa	9		60	Montmorency	3
19	Clinton	7		61	Muskegon	37
21	Delta	9		62	Newaygo	11

County Code	County Name	Beneficiary ID		County Code	County Name	Beneficiary ID
22	Dickinson	5		63	Oakland	76
23	Eaton	14		65	Ogemaw	1
24	Emmet	6		66	Ontonagon	1
25	Genesee	27		67	Osceola	4
26	Gladwin	1		68	Oscoda	1
27	Gogebic	4		69	Otsego	7
28	Grand Traverse	18		70	Ottawa	17
29	Gratiot	4		71	Presque Isle	1
30	Hillsdale	5		72	Roscommon	4
31	Houghton	5		73	Saginaw	5
32	Huron	5		74	St. Clair	11
33	Ingham	37		75	St. Joseph	12
34	Ionia	3		76	Sanilac	6
35	Iosco	1		78	Shiawassee	5
36	Iron	3		79	Tuscola	2
37	Isabella	4		80	VanBuren	5
38	Jackson	11		81	Washtenaw	40
39	Kalamazoo	58		82	Wayne	80
				83	Wexford	1
					TOTAL	**928**

Independence Plus and
Money Follows the Person Grants
February, 2007

MIChoice version of the Person-Centered Planning in Long-Term Care Policy and Practice Guideline

- Thanks to those of you who were involved with the PCP Action League for your valuable input on the draft PCP in LTC document. This document is now available for your review and comment.
- A companion document on PCP Implementation Elements was distributed to the Consumer Task Force last year for comment. This graphic has been expanded into a PowerPoint presentation.

Self-Determination Training, Documents and Conference Planning

- It is time to begin planning the 2007 June Self-Determination Conference. A planning meeting was held on February 16 with participation by Michigan Partners for Freedom. Information was gathered on format, presenters and other features of the conference. This event will be on June 11 & 12 at the Holiday Inn South in Lansing.
- A revision of the many of the documents describing the legal, programmatic and consumer support features for Self-Determined arrangements has been completed. Thanks to Ellen Sugrue Hyman for her efforts to accomplish these revisions. These documents have been submitted to the DCH Mental Health Administration for review.

1915bc Waiver Development

- An internal draft of a concept paper describing the scope, purpose and methods for a cost neutral Medicaid benefit in one or two counties in support of community living options for elders and persons with disabilities was presented to MSA and DCH staff for comment.
- The next step will be to discuss this Concept Paper with CMS.
- The Olmstead Coalition position paper on managed care was used to guide the development of the Concept Paper.

Update to the Consumer Task Force
Long-Term Care Supports and Services Advisory Commission
February 2007

At their January 22, 2007 meeting, the Commission discussed goals and activities for their February 26-27 retreat. The retreat will focus on building a broader understanding among Commissioners of the Task Force recommendations, issues orientation, developing a plan and establishing priorities for the conduct of Commission business in 2007, and defining the working relationship between the Commission and Office of LTC Supports and Services. The February Commission meeting has been cancelled in lieu of the retreat.

The Commission continued its review of progress made in implementing task force recommendations. Sarah Slocum provided a brief background regarding the creation of Recommendation #7 (Quality) and led a subsequent discussion of benchmarks. Sarah suggested that nursing home surveys should address consumer satisfaction in addition to regulatory issues.

Gary Heidel, from the Michigan State Housing Development Authority (MSHDA) made a presentation about housing options for seniors. Commissioner Hoyle raised an issue about special needs housing not being included in the MSHDA five-year plan. The plan includes a workgroup on supportive housing, which differs in definition from special needs housing. Mr. Heidel acknowledged that a misconception exists among builders

and designers that building for accessibility is more expensive.

The Commission was provided an update of grant activity conducted by the office. Several Commissioners are involved in the Systems Transformation Grant strategic planning activities. Commissioners were also informed of Office activities related to implementation of Public Act 634 (Single Point of Entry) and Public Act 674 (LTC Insurance Partnership Program).

There was no public comment provided at the meeting.

The next meeting will be held at 1:00 p.m. on March 26, 2007 in the MDCH Conference Center, 1st Floor, Capitol View Building, 201 Townsend St., Lansing.

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Person-Centered Planning
for Community Based Long-Term Care

Practice Guideline
February 2007

"Person-Centered Planning is a process for planning with and supporting the individual receiving services. The process builds upon the individual's capacity to engage in activities that promote community life and honors the individual's preferences, choices and abilities."

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Person-Centered Planning for Community Based Long-Term Care Practice Guideline February 2007

"Person-Centered Planning is a process for planning with and supporting the individual receiving services. The process builds upon the individual's capacity to engage in activities that promote community life and honors the individual's preferences, choices and abilities."

I. Purpose

The Person-Centered Planning process is a contract requirement for MI Choice waiver agents, which provide community-based long-term care services to people who are aging or have disabilities. This document provides guidance and technical assistance on how the Person-Centered Planning process can be successfully implemented with individuals participating in the MI Choice Medicaid waiver program and other community based long-term care services.

The Michigan Department of Community Health, Office of Long-Term Care Supports and Services has

convened a discovery and training process for MI Choice waiver agents and the long-term care community as a whole to identify exemplary practices in Person-Centered Planning. This policy and practice guideline is an outcome of that process.

The Person-Centered Planning process ensures that individuals who need long-term care supports and services have a method for identifying the care they want and need and how those supports and services are provided. The process enables individuals to maintain their lives in the community, increase their quality of life, and address health and welfare issues.

In the Person-Centered Planning process:

- Individuals know their options,
- Individuals make their own decisions,
- Individual decisions are driven by their life goals and priorities,
- Individuals have the support of allies in planning, developing and implementing their supports and services.

II. Person-Centered Planning Process (PCP) Definition

Person-Centered Planning is a method used to assist individuals in planning for how they wish to obtain the supports and services they need and want within the context of how they live their lives at home in their communities. The individual directs the planning process with a focus on what he or she wants and needs.

PCP is individualized, designed to respond to the desires and preferences expressed by the individual. As a process for planning and supporting the individual, it builds upon the individual's capacity to engage in activities that promote community life and honor the individual's preferences, choices and abilities. The process also can quickly adapt to changing needs and desires.

Often, individuals select allies to become involved in the Person-Centered Planning process; these allies may include family, friends, professionals, or caregiver staff. The involvement of allies is the choice of the individual; some people will choose not to involve any of their allies or will invite only a one or two people to participate. Professionals, who have traditionally been involved in the planning and

delivery of services, may have a role in the Person-Centered Planning process. The supports coordinator must be involved because he or she is responsible for authorizing the service plan. However, the development of the service plan, including the identification of possible supports and services and providers, is based on the expressed needs and desires of the individual rather than the recommendations of the professionals.

The individual's choices drive an ongoing process of setting goals (such as where they want to live, how they want to connect with others, the activities in which they want to participate) making plans, selecting supports and services, evaluating progress and outcomes, and revising or setting new goals. The goals and identified supports and services are incorporated into a service plan that includes both paid supports and services (such as MI Choice waiver services) and unpaid support (such as care provided by a spouse) that shapes service delivery implementation and is revised as needed.

III. Background

A. Shifting to a Person-Centered Model

The role of long-term care services is to assist individuals in meeting their health and welfare needs. Historically, long-term care service delivery has been based on the medical model, which focused on treating the health condition of concern. Medical professionals made decisions about treatment and service settings. The setting for long-term care was typically the nursing home. Federal regulations favored this approach. Recently, other community alternatives became more available.

B. History of Person-Centered Planning in Michigan

The movement toward person-centered planning has been growing in Michigan for the past two decades. Originally, person-centered planning was developed as a method for working with persons with developmental disabilities to identify their dreams, goals and preferences.

As the concept was introduced in Michigan in the late 1980s and early 1990s, the independent living philosophy was incorporated into the Person-

Centered Planning process so that the individual could use the planning process to develop the life he or she chooses in the community with work, meaningful activities, friends and relationships and other means of community involvement, just like everyone else. In 1996, legislation was passed that required individuals receiving supports and services in the public mental health system to develop an individual plan of services using a Person-Centered Planning process. In the last ten years, individuals with developmental disabilities and/or mental illness have used this process to pursue their goals to live, work and be involved in the community with the support they need and want.

C. Person-Centered Planning in Long-Term Care

The philosophy of Person-Centered Planning has been embraced statewide as the method for individuals who need long-term care to plan for supports and services to enable them to maintain their lives in their homes, neighborhoods and community and to maintain or obtain connections with other community members. The Michigan Medicaid Long-Term Care Taskforce was appointed by Governor Granholm in 2004 to: "examine and report on the current quality of Medicaid long-term

care services in Michigan and make recommendations for improvement in the quality of Medicaid long-term care services and home-based and community-based long-term care services provided in Michigan." The final Taskforce report identified Person-Centered Planning as a central policy recommendation. It recommended:

> "Use Person-Centered processes and tools to assess and match the individual's needs and desires across a continuum of LTC services based on demonstrated need, effective individualized management and care planning."

In addition, its seven other recommendations focused on individual choice and control by making available: a continuum of long-term care options, increased awareness and information, options for arrangements that support self-determination, and a well-compensated workforce.

D. Person-Centered Planning and Self-Determination

The terms *Person-Centered Planning* and *self-determination* are often confused by individuals who

are new to these concepts. While Person-Centered Planning is the method for identifying an individual's needs and desires and make meaningful choices regarding their lives, self-determination is the belief and value that individuals who need supports and services have freedom and authority to manage their individual budget and directly employ or contract with their service providers. All people who are receiving MI Choice waiver services have the right to develop their supports and services through the Person-Centered Planning process. By the end of 2007, individuals receiving services from any waiver agent in the state also will be able to choose to participate in the Michigan Self-Determination in Long-Term Care program, which enables individuals to choose and employ their own providers, including personal care workers, and to manage the individual budget of funding authorized by the waiver agent.

IV. Implementation of Person-Centered Planning

A. PCP Values and Principles

Person-Centered Planning is a highly individualized process designed to respond to the expressed needs/desires of the individual.

- Each individual has strengths and the ability to

express preferences and to make choices.

- The individual's choices and preferences shall always be honored and considered, if not always granted.

- Each individual can contribute to the community, and has the ability to choose how supports and services may help them meaningfully participate in and contribute to the community.

- Person-Centered Planning processes maximize independence, create community connections, and work towards achieving the individual's dreams, goals and desires.

- A person's cultural background shall be recognized and valued in the decision-making process.[1]

B. Essential Elements for Person-Centered Planning

There are a number of methods available to

[1] Adapted from Person-Centered Planning Policy and Practice Guideline, Michigan Department of Community Health, October 2002.

accomplish Person-Centered Planning, including, but not limited to: Individual Service Design, Personal Futures Planning, MAPS, Essential Lifestyle Planning, Planning Alternative Tomorrows With Hope. This Guideline does not endorse any particular method or model. Regardless of the model used or whether a formal model is used at all, the following characteristics of Person-Centered Planning are essential to the process of planning with an individual and his/her allies.

1. **Person Directed** The plan for the individual is the individual's vision of what he or she would like to be or do. The plan is not static, but rather it changes as new opportunities and challenges arise.

2. **Capacity Building** Planning focuses on an individual's gifts, talents and skills rather than deficits. It builds upon the individual's ability to engage in activities that promote a sense of belonging in the community.

3. **Person-Centered** The focus is continually on the individual for whom the plan is being developed and not on plugging the person into available slots in a program. The individual's choices and preferences

must be honored. If the individual does not communicate verbally, the process accommodates him or her to ensure that the individual's choices and preferences are honored. Guidance on Behavior as Communication is provided below.

4. Network Building The process brings people together on both an individual level (by involving allies in the planning process and honoring their role in individuals' lives) and system wide (by involving community members and by providing a mechanism for individuals receiving services to connect with one another and with community members as desired).

5. Outcome-Based The plan focuses on increasing any or all of the following experiences, which are valued by the individual:

- Growing in relationships or having friends
- Contributing or performing meaningful activities
- Sharing ordinary places or being part of their own community
- Gaining respect or having a valued role that expresses their gifts and talents
- Making choices that are meaningful and express individual identity

- Addressing health and welfare needs
- Planning for end of life care, when necessary.

6. Community Accountability The service plan will assure adequate supports when there are issues of health and welfare, while respecting each individual and according him or her dignity as a participating member of the community.[2]

7. Presumed Competence Person-Centered Planning is based on the premise that everyone has preferences that can form the foundation for how they want to live their life and what their dreams, goals and desires are. The focus is on these preferences instead of on an individual's disabilities, deficits, or level of capacity. In fact, all individuals are presumed to have the capacity to actively participate in the planning process. As described below, it is incumbent on the supports coordinator and the individual's allies to find a method to communicate with the individual and discern his or her preferences.

8. Information and Guidance When an individual is planning for arrangements that support self-determination, the Person-Centered Planning process

[2] Items #1-6 were adapted from resolution adopted by the Howell Group of Michigan, October 1994

must address the individual's need for information, guidance and support. Information and guidance may relate to the Person-Centered Planning process, options for supports and services, or it may directly relate to a particular need of the individual (such as what living situation would best meet the individual's needs and desires, what activities does the individual wish to pursue, strategies to build or rebuild and maintain relationships, or ways to become involved in the individual's community). Information and guidance is essential during the planning process, but also may be needed as service and supports are implemented.

Options should be drawn as broadly as possible from the ranges of long-term care services and generic community supports. Individuals must learn about options in ways that are useful to them. For some individuals, it may be sufficient to provide a written description of services at the beginning of the Person-Centered Planning process or when seeking information about an option. Other individuals may need to learn about options through explanation, observation or experience. The individual has the right to try an option before making a decision. The

timing for the learning and decision-making processes might need to be closely aligned.

9. Participation of Allies For most people, the Person-Centered Planning relies on the participation of allies chosen by the individual because of their commitment to support him or her. Most people living in their community already have the involvement of family members, friends, peers; these individuals constitute their allies. Individuals may also have important relationships with paid personal assistance workers or other professionals. Each individual's situation and relationships are unique; some individuals may have more support than others. Very few individuals have no informal support at all. Some people will want to seek out allies; others will choose to use the Person-Centered Planning process without them.

The participation of allies is important for broadening the planning input and sources of support. Allies can help individuals explore their options, articulate their vision of a desirable future, make choices for the future and find ways to solve problems. Chosen allies can be very helpful to the individual and to the supports coordinator in assisting and supporting the

individual on a continuing basis as needs arise. Together, the individual and his or her allies learn together and invent new courses of action to make the vision a reality. Individuals who cannot identify family members or friends to participate should be offered support for cultivating allies who can provide this very critical assistance.

10. Documentation The planning results should be documented in ways that are meaningful to the individual and useful to people with responsibilities for implementing the plan. The individual should be aware of and approve all distribution of planning documentation.

V. Practical Considerations in Person-Centered Planning

A. Planning for Health & Welfare

The service plan and Person-Centered Planning process must balance health and welfare issues with the individual's right to make his or her own choices. Specific issues of health and welfare must be examined and addressed so that an individual will not find himself or herself in a situation where he or she is at imminent risk. The supports coordinator is responsible for ensuring that issues of health, safety and welfare specific to the individual are brought up, discussed and resolved through the Person-Centered Planning process. Solutions must assure the health and welfare of the individual in ways that support attainment of his or her goals while maintaining the greatest feasible degree of personal control and direction.

Chief among these needs is planning for a workable back-up system to provide support in the event that providers are unable to be present for a work shift or duty. There a variety of ways to structure a back-up plan and an individual, with his or her supports coordinator and allies, can develop a back-up plan that meets the needs of the individual.

An individual may choose to address a sensitive health and welfare issue privately with the supports coordinator, rather than within a group planning process. Regardless of how it is done, the supports coordinator has an obligation to ensure that all health and welfare issues are addressed. When the individual makes a decision contrary to the support coordinator's or another professional's recommendation, the supports coordinator must ensure that the individual has information about all available options, document the individual choice, and revisit the issue as needed.

Sometimes, an individual's choices about how their supports and services are provided cannot be supported by the MI Choice waiver program, because the choices pose an imminent risk to the health and welfare of the individual or others. However, these decisions are made as part of the planning process in which the individual and their allies talk about the issues. Often the discussion leads to better alternatives that both meet the individual's needs and satisfy their dreams and goals.

B. Person-Centered Planning and Aging

The Person-Centered Planning process was originally developed and implemented with people with developmental disabilities. Often these were young people who were planning their whole life: the type of work or meaningful activities in which they would participate, where they would live, how they would develop friends and relationships.

Unlike younger people, older individuals have a whole lifetime of choices behind them. They have established a residence, chosen a career or life activities, found hobbies or other meaningful activities, developed friendships and relationships. Even when a person is unable to communicate because he or she has developed an incapacity, this lifetime of choices can be used to discern preferences and priorities. When a person is unable to communicate, life choices can be identified from the individual's surroundings (the presence or absence of photos; or the display of artwork, crafts, collections or awards).

Often, planning with older people focuses on how they can maintain or accommodate their current life. For example, an individual may need personal care or

environmental modifications to be able to stay in his or her lifelong home. A person who no longer has the strength or energy to pursue their lifelong hobbies may choose to explore new pastimes.

When a person is in the later stages of life, the challenge may not only be preserving and extending the sources of joy. The individual may need support with a source of frustration or sadness—for example, grieving a deceased spouse or healing a broken or strained relationship with a family member or friend.

For individuals who are dealing with end of life issues, the planning process may involve where an individual wants to die, what kind of life-sustaining treatment they want or do not want, and what measures they need to make them as comfortable as possible. The planning process may include a variety of ways to help an individual come to terms with the dying process and obtain needed closure.

C. Behavior as Communication

Supports Coordinators ensure that the individual has the chance to ask questions and the options and choices clearly explained and thoroughly discussed. If the individual needs help understanding something

or communicating thoughts, the individual, with his or her allies and/or supports coordinator must determine the best way to facilitate the individual's participation in the discussion.

People with disabilities communicate in a variety of ways. Some people use technology, others use hand signals, some use their voice, and others use picture systems. Some people can only signal yes or no using movement of their head, a hand, or another part of their body.

All people communicate through their behavior; for individuals who do not have other means of communication, behavior may be the primary means of communication. For many people who use behavior to communicate, their behavior may be seen as negative (they may yell, throw an item they do not want, throw a tantrum, or become aggressive).

Supports Coordinators and allies must learn to interpret an individual's behavior to determine what he or she may be communicating. Some behavior communicates emotions such as fear, discomfort, anger, or dislike. Other behavior communicates that the individual has a certain need or request or may want a certain solution or result. The behavior is

unique to the individual. Efforts must be made to understand the communication and to find positive methods for the individual to communicate.

D. Involvement of a Representative

An individual who does not have a guardian may designate another person to help him or her with the Person-Centered Planning process and in implementing the supports and services chosen in that process. Selecting a personal representative may be done formally, by executing a power of attorney, or informally, by asking the representative to serve. Through the Person-Centered Planning process, the individual and his or her allies may determine the best person or persons to serve as representative. A representative must be able and willing to honor the choices and preferences of the individual and support him or her to take as active role in the process as possible. In the event a personal representative is working counter to the individual's interests, the supports coordinator is authorized to address the issue and work with the individual to find an appropriate resolution.

E. Individual Monitoring and Evaluation of Progress and Outcomes

Just as the individual chooses his or her goals and the supports and services needed to achieve them, the individual should also evaluate progress toward those goals and the outcomes of the service plan. The supports coordinator can support the individual in this evaluation process (evaluation questions and surveys include standard ones required by the waiver agent or individual ones developed by the individual during the Person-Centered Planning process); they can be simple or lengthy. Evaluation may lead to reconvening the Person-Centered Planning process to modify the service plan or resolve a challenge that has arisen.

F. Independent Facilitation

An Independent Facilitator is a person chosen by the individual to guide him or her through the Person-Centered Planning process. An independent facilitator may be a family member or friend or may be an advocate recommended by a friend, provider or supports coordinator recommends. Whether an independent facilitator is used and whom the individual chooses for independent facilitation is up to the individual.

The individual may use an independent facilitator if he or she wants or needs to have someone that assists the individual and advocates for the individual's dreams and goals. Some individuals find it helpful to have a person involved who is outside of the waiver agent and does not make decisions to authorize supports and services and funding. Other individuals like having assistance in arranging the details of the meeting or leading the meeting. An independent facilitator can do one or all of these tasks.

The independent facilitator helps the individual with the pre-planning activities for the Person-Centered Planning process. These activities include who will be involved, the topics to be discussed, and the individual's goals and objectives. When the individual chooses to involve an independent facilitator, the supports coordinator may not be involved in the pre-planning process. The facilitator serves as the individual's advocate throughout the process, making sure that his or her needs and concerns are heard and addressed.

VI. The Steps of Person-Centered Planning

A successful Person-Centered Planning process puts individuals in charge of their own lives and planning, focuses on strengths, skills and/or life accomplishments, and acknowledges and honors individual preferences. A supports coordinator supports, guides, informs and assists the individual in learning about the Person-Centered Planning process and assures that the individual controls the Person-Centered Planning process. The planning process is not a single meeting. The individual may have a meeting every year, or more often, if needed. The individual may call a Person-Centered Planning meeting every time his or her wants and needs change.

Step #1 – Initial Contact & Getting Started

The Person-Centered process begins as soon as the individual enters the long-term care system and continues as the individual seeks changes. A supports coordinator chosen by the individual helps him or her navigate through the full array of services, supports, settings, and options. The supports coordinator ensures that the individual is provided with information regarding choices the individual can make. The supports coordinator provides information on the option for independent facilitation. Even if the

individual chooses an independent facilitator, the supports coordinator is involved in the Person-Centered Planning process and authorization of supports and services paid for by the waiver agent.

Step #2—Pre-Planning

Individuals must have opportunities to prepare for Person-Centered Planning process. This includes understanding the purpose, key aspects of the process (e.g. roles of the meeting participants, discussion questions for the meetings), and the options under consideration. The individual can choose to do a pre-plan with his or her supports coordinator, an independent facilitator or a trusted ally or allies. Preparation should occur in ways that are effective for the individual, which may include a planning meeting or meetings, role-playing or practice sessions, written information or other methods.

- **Scope of the planning** The individual determines the scope of the planning. Person-Centered Planning generally asks the person to think broadly about dreams, goals and priorities. However, an individual can choose to talk about a specific topic, or challenge or even what is working or not working in his or her daily life. Both can improve

an individual's quality of life and ability to maintain a life in the community.

- **Relationship between Person-Centered Planning and service plan** One implication of the broad scope of Person-Centered Planning is that it informs service or care planning; that is, the individual's life plans should give direction to supports and services that the individual needs in order to realize his or her goals. The Person-Centered Planning process is also the way the individual determines the type of supports and services he or she needs that are authorized and paid for by the waiver and who will provide the services and supports. This plan is called a service plan**.** The purpose of the plan is to help the individual to be as independent and self-sufficient as possible and build ways for them to participate in their community as desired. These supports and services include Medicaid covered services, waiver services, and services available from other government programs. The service plan must contain the date the service is to begin, the specified scope, duration, intensity of each service and who provides the service. The individual's plan may also include informal supports that family and friends

provide, as well as supports and services from other government programs.

- **Individual control over the planning process as well** The individual's choices include choosing the meeting participants, participant roles (e.g. who will facilitate), location, schedule, and meeting agenda. The site and time of the meetings should accommodate the individual and key allies. The agenda should include issues the individual wants to discuss; it should also exclude issues the individual does not want to discuss.

Topics for pre-planning

In pre-planning, the individual should think about and choose:

- the dreams, goals, desires and the topics the individual wants to talk about at the meeting
- likes and dislikes, what the individual would like more of or less in his or her life, and what the individual seeks to change
- topics the individual does not want talked about at the meeting
- who, among their friends, family members, professional providers, staff, and fellow community members the individual wants to

invite to participate in the Person-Centered Planning process
- where and when the meeting will be held
- who leads the meeting and the discussion. The individual may want to lead the discussion. The individual may want their supports coordinator to facilitate the meeting or they may want to select an independent facilitator to lead the discussion
- who records in writing what happens at the meeting

Topics for a Person-Centered Planning meeting

These will vary, depending on the individual, but could include:

- What are the individual's goals and dreams for the future or how do they want to live his or her life?
- What does the individual want more or less of in his or her life?
- Who does the individual want to spend time with?
- What new things would the individual like to do or learn?
- What are some great things others should know about the individual?

- What help and assistance does the individual need?
- What things could get in the way of the individual's dreams and goals?
- What does the individual like to do in his or her free time?
- What supports and services does the individual need to achieve his or her goals and dreams?
- What activities is the individual interested in? (job, hobbies, recreational activities, or volunteer opportunities)
- What health and welfare needs does the individual have?

Step #3 – The Person-Centered Planning Process

The planning process is not a single meeting. The individual may have a meeting every year, or more often, if needed. The individual may call a Person-Centered Planning meeting every time his or her wants and needs change.

A Person-Centered Planning meeting may begin with all of the participants introducing themselves and sharing why they are participating in the meeting. The meeting may start with what is currently working and not working for the individual. Or the

individual may start by sharing his or her hopes, dreams and desires for the future. Everyone gets to know the individual better and helps the individual with developing his or her plan to the extent help is asked for by the individual. The individual talks about what may get in the way of achieving his or her goals. It may be a physical or health issue or a skill that the individual wants or needs to learn, or a type of assistance or support that the individual needs. Health and welfare issues are also discussed.

After all of the issues are discussed, the individual and their allies work together to determine what supports and services the individual needs to achieve their goals and dreams and who can help the individual do so. These include the paid supports in the individual's service plan, and the unpaid supports such as the help the individual's friends, family members and other allies provide the individual. The plan may be completed in a single meeting or it may evolve over several sessions.

If the individual is unhappy with his or her service plan, the individual must let their supports coordinator know. The individual has the right to reconvene the Person-Centered Planning process or to

appeal through the Michigan Department of Community Health Fair Hearing Process. The waiver agent also has a dispute resolutions process.

VII. Organizational Readiness Components

Shifting from traditional service delivery methods to developing and implementing service plans through the Person-Centered Planning process requires a change in the organization's orientation. Instead of fitting individuals into existing programs, available supports and services must be adapted to meet the needs and desires of the individuals. The following characteristics are essential for organizations responsible for providing supports and services through the Person-Centered Planning process.

A. Person First Language

Person first language puts the person before the medical, physical or mental condition and maintains the emphasis on the humanity and dignity of the individual. For example, instead of *arthritic person*, the appropriate term would *person with arthritis*. Using person first language is an important first step in reorienting the organization toward the individuals and their needs and desires. Instead of viewing

individuals through the narrow scope of their condition or disability, the needs of the whole individual, as well as his or her support system, are identified and addressed.

B. Person-Centered Orientation

The focus must continually be on the individual for whom the plan is being developed and not on plugging that person into available slots in programs. Waiver agents have the responsibility to avoid unintended and detrimental consequences of their involvement, such as individuals becoming disempowered by deferring to professional decision-making, or families becoming displaced by service providers. The general strategy for avoiding these consequences is to presume competence and capacity by the individual, allies and the community, and to only provide assistance when the current situation. leave unmet needs. Just as the language for individuals receiving services has changed, the term supports coordinator has replaced terms such as care manager or case manager to identify the change in role from one who is managing or directing care to one who is supporting a individual to self direct their supports and services.

C. Training, Mentoring and Support for Staff

The staff should have training and supervision to ensure that they have the knowledge and capacity to meet their PCP responsibilities. These responsibilities may include: providing information and guidance to individuals receiving or seeking supports and services, facilitating the planning meetings as requested by the individual, suggesting creative strategies to address the needs and desires of the individual, and monitoring the effectiveness of the Person-Centered Planning process and service implementation. Training in the tools and methods of Person-Centered Planning process is critical in giving supports coordinators the background to support a variety of individuals and provide a unique response to each individual; peer mentoring and support may be helpful to develop support coordinator capacity in this area. In addition, support coordinator positions should be designed to accommodate this new role. For example, caseload size must allow for sufficient personal contact, authority to make decisions in support of the individuals' choices, flexible hours and minimal competing duties. Staff performance reviews should include consideration of how well the staff person contributes to Person-Centered Planning,

supports individual choice and helps realize individual goals.

D. Community Resource Development

Information on community resources must be available to all staff and individuals. Waiver agents must map community resources and options for community involvement and participation in which individuals express interest must be investigated. The waiver agent must work with other community and government organizations to resolve barriers and advance common aims. This collaborative may include developing resources to meet unmet needs and developing collaborative agreements to resolve barriers and ensure effective resource utilization.

E. Information and Guidance

Each waiver agent must have an organizational commitment to provide information and/or experiences that sufficiently inform an individual of her or his options. Upon initial screening and eligibility determination, supports coordinators must provide individuals and their allies with written information about the right to the Person-Centered Planning process. Supports coordinators may also ensure that individuals have tools to successfully use

the Person-Centered Planning process, develop individual quality service expectations that address preferences and evaluation of personal outcomes and goals, and implement arrangements that meet their needs. The supports coordinator must offer additional information and support to the individual and directly address concerns that the individual may have either over the phone or in a face-to-face meeting. Continued assistance is available throughout the planning process, which continues and evolves as each individual receives waiver services. This commitment should be met through multiple and flexible means of providing information. These might include alternative forms of communication (e.g. Braille, sign language, audio-recorded documents), hands-on experiences with options and peer support from individuals who have experience using the same supports and services. Individuals and their allies are provided with telephone numbers to contact supports coordinators when new needs emerge that require the assistance of the supports coordinator or the reconvening of the Person-Centered Planning process.

F. Evaluation and Quality Management

The effectiveness of both the person-centered planning process and the outcomes of that process must be evaluated. The approach to evaluation and quality management must collect and use data, including feedback from individuals on their views of the success of the Person-Centered Planning process and how the process impacts both the service plan development and service plan utilization. Data must be sought through multiple methods such as mail, phone or in-person surveys, focus groups, and other feedback loops.

Measures on the effectiveness and success of the person-centered planning process include whether: the individual invites allies important to them to participate in the process, the individual decides who will run person-centered planning meetings, the individual chooses meeting topics and the time and location of the meeting, and the individual's wants and needs are included in the service plan. A short written survey to evaluate the planning process must be provided to the participant with the authorized service plan; follow-up must be offered to assist the individual in completing the survey in the way that works best for him or her within 30 days of completion of the planning process.

Evaluation of the outcomes of the person-centered planning process include how the services and supports in the plan impact on the individual's ability to realize personal choices, maintain or increase individual's quality of life, and assist in achieving his or her dreams and goals. Data should also be collected and analyzed on the impact of the Person-Centered Planning process on individual choices—both realized and not realized, barriers to realizing choices and achieving goals, and efforts to resolve barriers and quality of life. This data should be collected and analyzed using the Participant Outcomes and Status Measures (POSM) Quality of Life Assessment at least annually.

This quality management process and resulting data is used to improve services and make decisions that lead to better lives for individuals. The goal is to develop a sense of the success of PCP from the individual's viewpoint. Individual preferences are identified in through the Person-Centered Planning process and the evaluation and quality management process needs to reflect the success of supports and services to both include and address these preferences. This management information should be

considered in organizational planning, including allocating resources.

VIII. Glossary

Allies Friends, family members and others that the individual chooses to assist him or her in the Person-Centered Planning process. Allies participate because of their commitment to supporting the individual, not because participation is one of their job duties. The individual determines who is an ally. Allies *may* include family members, friends, or advocates. Allies are not paid professionals (even though professionals may be very committed to supporting the individual).

Arrangements that support self-determination Methods for an individual to accomplish self-determination in his or her life.

Independent Facilitator A person the individual chooses to guide and support him or her through the Person-Centered Planning process.

Independent Living The term used for both the philosophy and the movement that all people with

disabilities, including people with significant disabilities, can maintain a life in the community—with work or other activities, a home, and personal relationships—if they have the right supports and services.

Service Plan The plan of supports and services for an individual that will be authorized and paid by the waiver agent.

Medicaid A government program that provides funding for supports and services authorized by the waiver agent.

Person-Centered Planning Process a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and honor the individual's preferences, choices and abilities.

Self-Determination The belief and value that individuals who need supports and services have the freedom to define their lives, make meaningful choices regarding their lives and have the

opportunity to direct the supports and services they need to pursue their lives.

Waiver Agent The agency that authorizes the individual's service plan.

Supports Coordinator A person who works for the waiver agent and works with an individual to develop and authorize a service plan. The supports coordinator also provides other assistance and support to the individuals they serve.

Long-Term Care Forum:
Planning for System Transformation

March 28, 2007, 9:00-4:00
Sheraton Hotel, Lansing

Offered by the Office of Long-Term Care Supports and Services, Michigan Department of Community Health

Purpose: Michigan received a 5-year Systems Transformation Grant from the Centers for Medicare and Medicaid Services. The grant work began with a group of consumers, advocates, providers and state agency staff drafted an implementation plan for the grant. This forum will share that plan and provide opportunities for input and discussion by a larger audience of stakeholders.

The plan addresses three major goals for long-term care in Michigan:

1. Improve access through development of a Single Point of Entry system
2. Increase consumer choice and control
3. Create a system of flexible financing so that "money follows the person"

Agenda:

9:00 Coffee, refreshments and registration
9:30 Update on Michigan's efforts in long-term care system change
10:30 Overview of the Implementation Plan
11:30 Lunch
12:30 Breakout sessions: Group discussions on each goal
3:00 Summary of input
4:00 Adjourn

Please join us to:

- Learn about this important grant initiative
- Understand the plans for implementing key elements of system transformation
- Share you ideas on we should pursue these goals

Audience:
Leaders and representatives of long-term care stakeholder groups: consumers, family members, advocates, providers, local and state agency staff.

Cost: $25.00 (includes lunch).

Registration*: Advance registration required. There will be no registration at the door. Space is very limited We will confirm your registration and maintain a waiting list, if necessary.*
Registration deadline: March 21, 2007

See attached Registration Form.

Long-Term Care Forum:
Planning for System Transformation

March 28, 2007, 9:00-4:00
Sheraton Hotel, 925 S. Creyts Road, Lansing, 517-323-7100
Offered by the Office of Long-Term Care Supports and Services,
Michigan Department of Community Health

Cost (please check one):
❒ $25, includes lunch
❒ $0: No charge for planning workgroup members

3 EASY WAYS TO REGISTER!!!!!

ONLINE: WWW.MACMHB.ORG
(Click on to conferences & trainings)

FAX: 517-374-1053

BY MAIL
MACMHB
426 S. Walnut
Lansing, MI 48933

NO REGISTRATION AT THE DOOR

(Please Type or Print)

First/Last Name:_____ **Title:**_____

Agency/Board:_____

Address:_____ **City/State/Zip:**_____

Phone:_____ **Fax:**_____

Email:_____

Special Needs**:** **If you have special needs, please specify:** _____
Arrangements for special needs will be honored for those written requests received 10 business days prior to the training. Clearly state your specific needs for dietary restrictions, mobility assistance, interpreters, etc. All attempts for on-site requests will be made.

Cancellation Policy: Substitutions are permitted at any time. No shows will be billed at the full training rate. Cancellations must be received in writing at least 10 business days prior to the training for a refund. If the cancellation is received less than 10 business days prior to the training, no refund can be given.

Payment Method: **Register now to reserve your spot at this forum. Payment does not need to accompany registration form; however, payment or purchase order must be received by the day of the training. Please note that confirmation letters are NOT sent. If you require confirmation, please contact Georjean Knapp at mryals@macmhb.org or 517-374-6848.**

[ ] Check enclosed (made payable to MACMHB)
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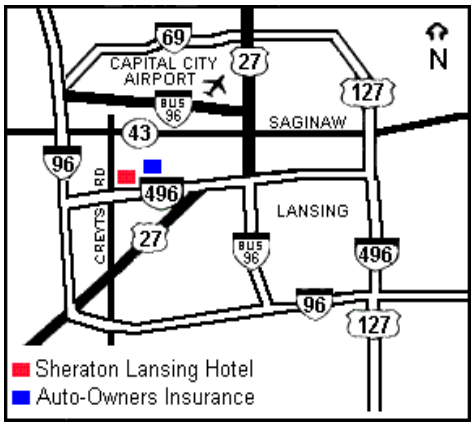
Charge to: [ ] Visa [ ] Master Card [ ] American Express [ ] Discover

#_____ **Expiration Date:**_____

Card holder name/phone#:_____

Questions?? Call MACMHB at 517-374-6848



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517-323-7100 FAX 517-323-2180
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From The North -- St. Johns and Upper Peninsula
Follow US-27 South towards Lansing to I-69 west (Exit #89) continue on I-69 west. Continue to head towards Charlotte/Ft Wayne, I-69 West merges with I-96 east. Go to I-496 (Downtown Lansing Exit #95). Go one mile on I-496 to Creyts Road (exit #1). Turn left on Creyts Road; turn right at first light (Anacapri Blvd.) The Sheraton is the second drive on the right.

From The South -- Jackson Area
Follow US-127 North towards Lansing to I-96 west (towards Gr. Rapids); continue on I-96 to I-496 east (downtown Lansing exit #95). Take Creyts road (Exit #1). Turn left on Creyts Road. Turn right at the first light (Anacapri Blvd.). The Sheraton is the second drive on the right.

From the South -- Battle Creek Area
Follow I-69 north towards Lansing. I-69 will merge with I-96 west. Continue to I-496 east (Downtown Lansing Exit #95) Take Creyts Road (exit #1) and turn left on Creyts Road. Turn right at the first light (Anacapri Blvd.). The Sheraton is the second drive on the right.

From the East --Detroit Area
Take I-96 west towards Lansing to I-496 west (Exit # 106B). Continue on I-496 to Creyts Road North (Exit 1B). Take this exit and turn right on Creyts Road. Take a right at the first light (Anacapri Blvd.). The Sheraton is the second drive on the right.

From the West -- Grand Rapids
Take I-96 east towards Lansing to I-496 east. Continue on I-496 to Creyts Road (Exit 1). Take this exit and turn left on Creyts Road. Take a right at the first light (Anacapri Blvd.). The Sheraton is the second drive on the right.

From the Northeast -- Flint/Saginaw
Follow I-69 west towards Lansing. Head towards Charlotte/Ft. Wayne, I-69 merges with I-96 east. Go to I-496 east (Downtown Lansing Exit #95). Go one mile to Exit #1 (Creyts Road). Turn left on Creyts Road. Turn right at the first light (Anacapri Blvd.). The Sheraton is the second drive on the right.

FROM CAPITAL CITY AIRPORT
From the Airport (at the light), make a right onto Grand River. Continue on Grand River to Waverly Road. Turn left onto Waverly Road. Take Waverly Road to Saginaw Highway (4th light). Turn right onto Saginaw Hwy. Continue on

Saginaw Road to Creyts Road (4th light). Make a Left turn onto Creyts Road. Pass Michigan Avenue and St. Joseph Highway. The Sheraton Hotel will be the left (at the 3rd light).

FROM DETROIT METRO AIRPORT

Take I-94 to 275 North to I-96 West to I-496 West. Take the North Creyts Road exit (#1B). Turn Right onto Creyts Road. Turn right at the first light (Anacapri Blvd.). The Sheraton is the second drive on the right.